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After A.S.: Proposals to Alleviate Psychiatric Boarding in Maine

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After A.S.: Proposals to Alleviate Psychiatric Boarding in Maine

Cover Page Footnote

Master of Policy, Planning, and Management; University of Maine School of Law Class of 2023. I am grateful to my Case Note advisor, Professor Jennifer Wriggins, for her support and guidance during this process; to Emma Bond, Kevin Voyvodich, and James Bailinson for their advice and ideas for developing this area of law; the Maine Law Review team for their time and attention to this piece; my family for their support and words of motivation; and Marshall. To A.S., I hope you have found peace and safety. Finally, I would like to thank all of my friends for always encouraging me to do my best work but to also take time to enjoy life: Kelsey, Shannen, Sadie, Claire, Megan, Natasha, Dana, Kaylee, and so many more.

AFTER *A.S.*: PROPOSALS TO ALLEVIATE PSYCHIATRIC BOARDING IN MAINE

Meredith K. Cook

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AFTER A.S.: PROPOSALS TO ALLEVIATE PSYCHIATRIC BOARDING IN MAINE

Meredith K. Cook*

ABSTRACT

When someone presents to an emergency room with a mental illness manifesting in danger to themselves or others, they can be admitted against their will on an emergency basis to inpatient mental health care through a process colloquially known as a Blue Paper application. However, when an inpatient bed is not immediately available, patients are “boarded” against their will in emergency rooms with little to no therapeutic care, sometimes for several weeks at a time before they are transferred to inpatient care, or their condition stabilizes enough for them to be discharged into the community.

In February 2020, a man identified to the public only by his initials, A.S., was brought by law enforcement to LincolnHealth’s Miles Hospital Campus in Damariscotta where he would stay against his will for a total of thirty days. He filed a petition for a writ of habeas corpus, which was denied, and appealed his case to the Maine Supreme Judicial Court. The Maine Supreme Judicial Court, sitting as the Law Court, recognized that A.S.’s due process rights were abridged while at the same time clarifying the legal procedures that allow others to be subjected to extended periods of psychiatric boarding in emergency rooms across Maine.

This Note summarizes the historical and legal underpinnings of involuntary civil commitment. It then explains the recent history of Maine’s involuntary commitment statute that led to A.S.’s extended psychiatric boarding. This Note then provides a detailed explanation of his case, *A.S. v. LincolnHealth*. It then analyzes the statutory interpretation central to the holding of the case. Finally, this Note proposes several short-term administrative and judicial actions that should be taken to alleviate the problem of psychiatric boarding in Maine.

INTRODUCTION

On February 24, 2020, law enforcement officers brought a man, identified to the public only by his initials, A.S., to the emergency department of LincolnHealth’s Miles Hospital Campus in Damariscotta in apparent mental distress.¹ After medical staff determined that A.S. posed a likelihood of serious harm to himself or others due to a mental illness, staff completed sixteen Blue Paper applications and detained him

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1. *A.S. v. LincolnHealth*, 2021 ME 6, ¶ 1, 246 A.3d 157.

in the emergency room for thirty days against his will.² A.S. was subjected to the phenomenon known as psychiatric boarding, which occurs when a person in need of inpatient mental health care is held in an emergency department while awaiting an appropriate inpatient placement.³ He filed a petition for a writ of habeas corpus, which the trial court denied despite the hospital's failure to comply with the statutory requirements for holding a person in the emergency room against their will.⁴ On the thirtieth day of his involuntary detention, A.S. was released from the emergency room and would later be vindicated by the Maine Supreme Judicial Court, sitting as the Law Court, when it vacated the trial court's denial of his habeas corpus petition.⁵ Although the court announced that both the trial court and the hospital violated statutory procedures and A.S.'s due process rights,⁶ it acknowledged that a legal pathway exists that allows a person to be held in an emergency room for just as long as A.S. was with minimal due process protections.⁷ To announce that pathway, the court relied on a strained, but nevertheless understandable, statutory interpretation given the court's limited power to remedy the root causes of psychiatric boarding in emergency rooms across Maine.⁸ After *A.S.*, people with mental illness in Maine are still at risk of experiencing extended periods of psychiatric boarding with only modest due process protections. Section I of this Note will explore the historical and legal underpinnings of involuntary civil commitment and the recent history of the statute at issue in *A.S.* Section II will explain the issues and holdings of the case itself and provide an analysis of the statutory interpretation central to the case. Section III will discuss developments that came after the opinion was issued and achievable short-term reforms to alleviate the instances and lengths of psychiatric boarding in Maine.

I. BACKGROUND

A. Involuntary Civil Commitment in the United States

When a person's mental illness manifests in danger to themselves or others, healthcare providers rely upon the process of involuntary civil commitment to admit such persons to inpatient psychiatric hospitals.⁹ This is because refusal of psychiatric care is a common occurrence among people with mental illness due to impaired insight and judgment.¹⁰ An overview of the historical and legal underpinnings of

2. *See id.*

3. Lois A. Weithorn, *Envisioning Second-Order Change in America's Responses to Troubled and Troublesome Youth*, 33 HOFSTRA L. REV. 1305, 1369 (2005) ("The term 'boarding' in this context refers to the phenomenon of persons with mental disorders remaining in hospital emergency rooms while waiting for mental health services to become available.").

4. *A.S.*, 2021 ME 6, ¶ 1, 246 A.3d 157.

5. *Id.* ¶¶ 8, 38.

6. *Id.* ¶¶ 36-37.

7. *See id.* ¶ 25.

8. *See id.*

9. Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 PSYCHIATRY (EDGEMONT) 30, 31 (2010).

10. *Id.*

civil commitment is crucial to understand the forces that brought A.S. to the emergency room and kept him there for thirty days against his will.¹¹

*1. A Brief History of Mental Health Treatment: Founding Through
Deinstitutionalization*

At the time of the founding of the United States, those with mental illness who could not care for themselves and did not have family to support them were often jailed or housed in poor houses with inhumane, unsanitary conditions and no treatment for their mental condition.¹² Beginning in the early 1800s and proceeding through the middle of the 19th Century, reformers sparked a movement for more humane treatment of people with mental illness, bringing care for the individual to the center of mental healthcare policy for the first time in the United States.¹³ Four privately funded asylums opened their doors in northeastern states between 1817 and 1824, followed by the establishment of state-run asylums, thus spurring the period of institutionalization which proliferated for over a century.¹⁴ Although treatment and care for individuals motivated the movement to institutionalization, the “treatments” used in institutions were often ineffective, failed to prepare patients for life outside the institution, and largely consisted of restraints, sedation, and experimental drug treatments.¹⁵ The American eugenics movement of the early- to mid-20th Century flourished in asylums.¹⁶ Of the more than 60,000 forced sterilizations of the American eugenics period, many of them were performed in institutions for the mentally ill, and many who were subjected to forced sterilization were people of color.¹⁷ The only criteria for admission to mental institutions during this period were the presence of mental illness and a need for care.¹⁸ There were

11. The process is also sometimes referred to as “involuntary hospitalization,” but this Note will use the phrase “civil commitment” for consistency and clarity. *See id.*

12. Stuart A. Anfang & Paul S. Appelbaum, *Civil Commitment — The American Experience*, 43 *ISR. J. PSYCHIATRY & RELATED SCIS.* 209, 209 (2006).

13. *Id.* at 210.

14. Testa & West, *supra* note 9, at 32. The first state-run institution, Worcester State Hospital, opened in 1833. *See* Anfang & Appelbaum, *supra* note 12, at 210.

15. Testa & West, *supra* note 9, at 32.

16. *See* Alexandra Minna Stern, *That Time the United States Sterilized 60,000 of its Citizens*, *HUFFPOST* (Jan. 7, 2016), https://www.huffpost.com/entry/sterilization-united-states_n_568f35f2e4b0e8beacf68713 [<https://perma.cc/T2JM-9K56>].

17. *See id.* Carrie Buck, the “feeble-minded” woman at the center of *Buck v. Bell*, was committed to the State Colony for Epileptics and Feeble Minded where she was ultimately sterilized. *Buck v. Bell*, 274 U.S. 200, 205 (1927). Black women faced disproportionately higher rates of forced sterilization than white women, black men, and white men. *See* Alexandra Minna Stern, *Forced Sterilization Policies in the US Targeted Minorities and Those with Disabilities — And Lasted into the 21st Century*, *UNIV. MICH. INST. FOR HEALTHCARE POL’Y & INNOVATION* (Sept. 23, 2020), <https://ihpi.umich.edu/news/forced-sterilization-policies-us-targeted-minorities-and-those-disabilities-and-lived-21st> [<https://perma.cc/Q747-PD5A>] (explaining that Black women in North Carolina, a prolific sterilization state, were the most likely demographic group to be forcibly sterilized). In Maine, of the 326 total sterilizations performed between 1925 and 1963, 189 were performed at the same location—Pineland Hospital (originally Maine School for the Feeble-Minded) in New Gloucester, Maine. *See* Lutz Kaelber, *Eugenics: Compulsory Sterilization in 50 American States: Maine*, *UNIV. OF VT.*, <https://www.uvm.edu/~lkaelber/eugenics/ME/ME.html> [<https://perma.cc/XDV6-5B9W>] (last visited May 11, 2022).

18. Anfang & Appelbaum, *supra* note 12, at 210.

few, if any, procedural safeguards to prevent involuntary admission,¹⁹ and the system was vulnerable to abuse by family members and physicians who forced sane people into unnecessary hospitalization.²⁰

Growing awareness of the abuses of civil commitment prompted states to enact procedural safeguards similar to those afforded to criminal defendants, thus bringing civil commitment under the purview of judicial process.²¹ However, by the late 1940s and early 1950s, advocates became concerned that the criminal-like procedures would have adverse effects on the people subjected to them.²² This concern led procedural policies to shift again in favor of medical providers as the arbiters of commitment.²³ At its peak in the 1950s, the population of psychiatric inpatients in the United States exceeded 550,000.²⁴ By the 1960s, public pressure to reform the mental health system, the advent of antipsychotic medications, and psychiatry's embrace of community-based outpatient treatment converged to spell the end of the institutionalization era.²⁵

The Community Mental Health Act of 1963, signed into law by President John F. Kennedy, became a vehicle for deinstitutionalization by providing the states with funding to establish and operate 1,500 community mental health centers across the country.²⁶ From the signing of the Act through the 1990s, state hospitals shuttered and the population of psychiatric inpatients plummeted to around 30,000.²⁷ Although the hospitals closed and patients were transitioned into society, the robust community mental health safety net the Act was intended to provide never came to fruition.²⁸ States only built approximately half of the 1,500 community mental health centers called for by the Act.²⁹ Oversight and regulation were particularly difficult due to the heterogenous nature of the centers that were built, and many of the new centers focused on the treatment of less-severe mental illnesses.³⁰ The end result left people with severe mental illness with few resources because no single organization or authority was vested with the ultimate responsibility for their care.³¹ The aims of deinstitutionalization were laudable, but its execution forced the severely mentally ill into homelessness, jails, prisons, and acute care hospitals.³²

19. Testa & West, *supra* note 9, at 32.

20. Anfang & Appelbaum, *supra* note 12, at 210.

21. Testa & West, *supra* note 9, at 32.

22. Anfang & Appelbaum, *supra* note 12, at 210-11.

23. *Id.*

24. Testa & West, *supra* note 9, at 32.

25. *Id.* at 33.

26. Blake Erickson, *Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963*, 16 AM. J. PSYCHIATRY RESIDENTS' J. 6, 6-7 (2021).

27. Testa & West, *supra* note 9, at 33.

28. *See* Erickson, *supra* note 26, at 7.

29. *Id.*

30. *Id.*

31. *Id.*

32. *Id.*

2. *The Legal Underpinnings of Civil Commitment*

The movement for deinstitutionalization coincided with heightened admission standards for civil commitment and more uniform procedural safeguards. States began enacting statutes requiring a person to be mentally ill and present an imminent threat of danger to oneself or others in order to be civilly committed.³³ This marked the abandonment of the need-for-treatment model of the institutionalization era in favor of a dangerousness model.³⁴

The procedural safeguards accompanying these statutes left open the question of what standard of proof is necessary to commit a person for an indefinite period while still satisfying due process guarantees. However, the Supreme Court addressed this question in *Addington v. Texas*.³⁵ The Court weighed the individual's liberty interest in not being involuntarily committed for an indefinite period of time against the state's interest in committing "the emotionally disturbed" with an eye toward minimizing the risk of erroneous decisions.³⁶ In considering these interests, the Court observed that the heightened standard of clear and convincing evidence would "impress the factfinder with the importance of the decision and thereby perhaps [] reduce the chances that inappropriate commitments [would] be ordered."³⁷ The Court also determined that "[t]he individual should not be asked to share equally with society the risk of error [under the preponderance of the evidence standard] when the possible injury to the individual is significantly greater than any possible harm to the state."³⁸ After making these observations, the Court ultimately held that, at a minimum, the clear and convincing evidence standard was necessary to satisfy due process because the "middle level [] burden of proof [] strikes a fair balance between the rights of the individual and the legitimate concerns of the state."³⁹ In so holding, the Court rejected *Addington's* assertion that the beyond a reasonable doubt standard should govern because the "concern that the risk of error to the individual must be minimized even at the risk that some who are guilty might go free" in the criminal context does not apply in the civil commitment context.⁴⁰ The Court reasoned that "[o]ne who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma."⁴¹

B. Contemporary Civil Commitment in Maine

Current civil commitment laws in Maine largely reflect the procedural and substantive principles discussed above and are embodied in statute in section 3863-3864 of title 34-B of the Maine Revised Statutes.⁴² Section 3863 outlines the emergency procedure for people with mental illness manifesting in imminent risk of

33. Testa & West, *supra* note 9, at 33.

34. *Id.*

35. *Addington v. Texas*, 441 U.S. 418, 419-20 (1979).

36. *Id.* at 425.

37. *Id.* at 427.

38. *Id.*

39. *Id.* at 432-33.

40. *Id.* at 429.

41. *Id.*

42. See 34-B M.R.S. §§ 3863-3864 (2021).

serious harm to oneself or others and section 3864 outlines the procedures for longer-term judicial commitment.⁴³ Also relevant is section 3804, which authorizes the writ of habeas corpus for those detained in a hospital for mental health reasons.⁴⁴ The following section of this Note will first outline the statutory requirements under sections 3863 and 3864 and then consider the recent history of section 3863 leading up to the decision in *A.S.*

1. Section 3863: Emergency Procedure (Blue Paper)

The procedure to admit a person to a psychiatric hospital on an emergency basis begins with an application that must be endorsed by a justice or judge.⁴⁵ This application is known colloquially as the “Blue Paper.”⁴⁶ The application can be made by a health officer, law enforcement official, or any person,⁴⁷ but is usually initiated by hospital emergency rooms after a person in mental distress self-presents seeking treatment or is brought to the emergency room by law enforcement or family in apparent mental distress.⁴⁸ The application must state “[t]he applicant’s belief that the person is mentally ill and, because of the person’s illness, poses a likelihood of serious harm; and . . . [t]he grounds for this belief.”⁴⁹ The application must also be supported by a certificate of examination by a medical practitioner, stating the following:

- A. That the practitioner has examined the person on the date of the certificate;
- B. That the medical practitioner is of the opinion that the person is mentally ill and, because of that illness, poses a likelihood of serious harm. The written certificate must include a description of the grounds for that opinion. The opinion may be based on personal observation or on history and information from other sources considered reliable by the examiner, including, but not limited to, family members; and
- C. That adequate community resources are unavailable for care and treatment of the person’s mental illness.⁵⁰

The application and certificate are then reviewed by a judge or justice, and, if the judge or justice is satisfied that they are “regular and in accordance with the law,” the judge or justice will endorse the forms and promptly send the forms to the

43. *See id.*

44. 34-B M.R.S. § 3804 (2021).

45. *Id.* § 3863(1), (3).

46. *See* Me. Dep’t of Health & Hum. Servs., State of Maine “Blue Paper” Application for Emergency Involuntary Admission to a Psychiatric Hospital (Mar. 1, 2021), https://www.maine.gov/dhhs/sites/maine.gov/dhhs/files/inline-files/Blue-Paper-MH-100.A%28Rev.-March-2021%29_0.pdf [<https://perma.cc/8GJR-2RHY>].

47. 34-B M.R.S. § 3863(1).

48. *See, e.g., A.S. v. LincolnHealth*, 2021 ME 6, ¶ 9, 246 A.3d 157; *In re Christopher H.*, 2011 ME 13, ¶ 2, 12 A.3d 64; *In re Penelope W.*, 2009 ME 81, ¶ 2, 977 A.2d 380.

49. 34-B M.R.S. § 3863(1) (2021).

50. *Id.* § 3863(2).

“admitting psychiatric hospital.”⁵¹ Once the certifying examination has taken place, the person may be held in the hospital for up to twenty-four hours pending judicial endorsement.⁵² At the end of this initial twenty-four hour hold period, if no suitable placement has been found, the person may be held for another forty-eight hour period so long as: (i) the hospital undertakes its best efforts to find an inpatient bed or appropriate alternative; (ii) an appropriate evaluator concludes the person is mentally ill and poses a likelihood of serious harm due to mental illness; and (iii) the hospital notifies the Department of Health and Human Services (DHHS) of the individual’s identity, presence, evaluation, and time of entry to the hospital.⁵³ If, at the end of the forty-eight hour hold, a suitable placement still is not secured, the person may be held for one additional forty-eight hour period so long as the same requirements of the first forty-eight hour period are met, and DHHS provides its best efforts to find a placement.⁵⁴ Notably, the statute is silent on what should happen if the second forty-eight hour period elapses and no placement is found.⁵⁵ Once an inpatient psychiatric bed has been located and the patient has arrived at that location, the inpatient hospital has three days from the date of admission to submit an application for longer-term judicial commitment.⁵⁶

2. Section 3864: Judicial Procedure and Commitment (White Paper)

Once a person is transferred to inpatient psychiatric care pursuant to a Blue Paper application, if the inpatient hospital wishes to have the patient committed for longer than three days, the hospital must submit an application under section 3863(5-A)⁵⁷ (known colloquially as the “White Paper”).⁵⁸ Upon receipt of the White Paper application, the district court must schedule an evidentiary hearing within fourteen days of the application date.⁵⁹ During this stage of the civil commitment process, the hospital must comply with various notice and examination requirements.⁶⁰ The patient is entitled to be represented by court-appointed counsel at the commitment hearing.⁶¹ For the court to enter an order of judicial commitment, it must find each of the following by clear and convincing evidence:

51. *Id.* § 3863(3)(A). As acknowledged by the Law Court in *A.S. v. LincolnHealth*, the current reality of inpatient psychiatric bed availability necessarily changes the process at this point. *See A.S.*, 2021 ME 6, ¶ 16, 246 A.3d 157. Even if there is no psychiatric bed available at the time the application is submitted for endorsement, the application must still be submitted to a judge or justice for their endorsement of the application with the understanding that the applicant is still seeking an inpatient bed. *See id.* ¶ 37.

52. 34-B M.R.S. § 3863(3)(B) (2021).

53. *Id.* § 3863(3)(D).

54. *Id.* § 3863(3)(E).

55. *See id.* § 3863(3).

56. *Id.* § 3683(5-A)(C).

57. *Id.*

58. *See Involuntary Admissions*, STATE OF ME. DEP’T OF HEALTH & HUM. SERVS., <https://www.maine.gov/dhhs/obh/support-services/rights-and-legal-issues/involuntary-admissions> [https://perma.cc/96GU-NUXC] (last visited May 11, 2022).

59. 34-B M.R.S. § 3864(5)(A) (2021).

60. *See id.* § 3864(3)-(4).

61. *Id.* § 3864(5)(D).

- (1) . . . [T]hat the person is mentally ill and that the person's recent actions and behavior demonstrate that the person's illness poses a likelihood of serious harm;
- (1-A) That adequate community resources for care and treatment of the person's mental illness are unavailable;
- (2) That inpatient hospitalization is the best available means for treatment of the patient; and
- (3) That it is satisfied with the individual treatment plan offered by the psychiatric hospital to which the applicant seeks the patient's involuntary commitment.⁶²

If the court makes those findings, it may order commitment for a period of up to four months in the first instance and up to one year in all subsequent hearings.⁶³

3. *Stuck Between the Sections: Psychiatric Boarding in Maine*

Psychiatric boarding is the practice of holding patients in need of inpatient psychiatric treatment involuntarily in emergency rooms until an inpatient bed is available.⁶⁴ Psychiatric boarding triggers legal problems in Maine when no appropriate placement becomes available within the first 120 hours, which is the duration that the emergency room is authorized by statute to hold a patient awaiting admission to inpatient treatment.⁶⁵ At such point, the statute is silent on what the proper procedure is for continuing to hold a patient presenting a likelihood of serious harm.⁶⁶ The emergency room is under a federal legal duty to hold the patient until they are transferred to appropriate care or stabilized,⁶⁷ but the state statute appears to support discharging the patient at the end of the 120-hour period unless the patient agrees to stay voluntarily.⁶⁸

It is difficult to know how often emergency rooms in Maine are being forced to board patients because of limited inpatient bed availability and who is being subjected to psychiatric boarding because DHHS does not publish such data and may not even collect it.⁶⁹ Even at the national level, data on the prevalence, length, and demographics of psychiatric boarding is scant due to the lack of a standard definition of emergency room boarding.⁷⁰ Data from 2008, the most recent available, indicates that 21.5% of all patients nationwide who presented to emergency departments with

62. *Id.* § 3864(6)(A).

63. *Id.* § 3864(7).

64. Lois A. Weithorn, *Envisioning Second-Order Change in America's Responses to Troubled and Troublesome Youth*, 33 HOFSTRA L. REV. 1305, 1369 (2005).

65. *See* A.S. v. LincolnHealth, 2021 ME 6, ¶ 16, 246 A.3d 157.

66. *See* 34-B M.R.S. § 3863(3) (2021).

67. Emergency Medical Treatment & Labor Act, 42 U.S.C. § 1395dd. The Act requires emergency medical services to stabilize a patient's emergency medical condition on site or transfer a person to a facility where they will be stabilized regardless of the patient's insured status or ability to pay. *Id.* § 1395dd(b).

68. *See* 34-B M.R.S. § 3863(3) (2021).

69. *See Data & Research*, STATE OF ME. DEP'T OF HEALTH & HUM. SERVS., <https://www.maine.gov/dhhs/obh/about/data-research> [<https://perma.cc/L6NE-PMRD>] (last visited May 11, 2022).

70. Jason M. Nolan et al., *Psychiatric Boarding Incidence, Duration, and Associated Factors in United States Emergency Departments*, 41 J. EMERGENCY NURSING 57, 57-58 (2015).

psychiatric complaints were boarded in the emergency room.⁷¹ Despite the lack of more recent data, data points suggest the incidences are likely rising. For instance, a 2016 survey revealed that nearly half of emergency physicians reported that daily psychiatric boarding was occurring in their emergency departments more often than it previously had.⁷² Additionally, in Maine, the number of White Paper filings in the district courts rose from 893 in fiscal year 2016 to 1,190 in fiscal year 2020.⁷³ A study of emergency department visits from October 2014 to September 2015 in Oregon found that 30.2% of all psychiatric emergency room visits resulted in the patient being boarded while awaiting admission to inpatient treatment.⁷⁴ This study also found that certain demographic characteristics, such as age, race, and whether the patient lived in an urban or rural setting were associated with a heightened likelihood of psychiatric boarding.⁷⁵ For example, Black patients were 2.7% more likely to be boarded than white patients.⁷⁶

Psychiatric boarding presents problems not just for the patients' liberty and due process rights, but also for their treatment and outcomes because psychiatric patients who are boarded in emergency departments receive little, if any, therapeutic treatment. Sixty-two percent of emergency department directors surveyed reported that their departments provided no psychiatric services for boarded psychiatric patients.⁷⁷ Psychiatric patients boarded in emergency departments frequently experience further deterioration to their mental health because of the loud and hectic environment, and they are at higher risk of being subjected to chemical sedation and physical restraints the longer they are boarded in an emergency department.⁷⁸ Further, the prevalence of psychiatric boarding burdens the emergency healthcare system as a whole. Boarding psychiatric patients strains limited emergency department resources, which negatively impacts patient outcomes for all emergency department patients, not just those presenting with psychiatric complaints.⁷⁹

4. Recent History of Section 3863

The Law Court was presented with the issues of psychiatric boarding and the statutory interplay between sections 3863 and 3864 of title 34-B of the Maine Revised Statutes when it decided *In re Marcia E.* in 2012.⁸⁰ In that case, the patient,

71. Jeremy R. Simon et al., *The Impact of Boarding Psychiatric Patients in the Emergency Department: Scope, Impact and Proposed Solutions*, AM. COLL. EMERGENCY PHYSICIANS (Nov. 2019), <https://www.acep.org/globalassets/new-pdfs/information-and-resource-papers/the-impact-of-psychiatric-boarders-on-the-emergency-department.pdf> [<https://perma.cc/W4US-3NGG>].

72. *Id.*

73. *Maine State Court Caseload 5 Year Trend*, STATE OF ME. JUD. BRANCH, <https://www.courts.maine.gov/about/stats/statewide.pdf> [<https://perma.cc/98HD-9ZJZ>] (last visited May 11, 2022).

74. Jangho Yoon et al., *Determinants of Boarding of Patients with Severe Mental Illness in Hospital Emergency Departments*, 23 J. MENTAL HEALTH POL'Y & ECONS. 61, 63 tbl.1 (2020).

75. *Id.* at 64-66.

76. *Id.* at 66.

77. Simon et. al., *supra* note 71.

78. *Id.*

79. See B. A. Nicks & D. M. Manthey, *The Impact of Psychiatric Patient Boarding in Emergency Departments*, NAT'L INSTS. OF HEALTH (July 22, 2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3408670/> [<https://perma.cc/2TP8-TKA2>].

80. See *In re Marcia E.*, 2012 ME 139, ¶ 3, 58 A.3d 1115.

Marcia E., challenged the validity of her ultimate commitment to inpatient care under section 3864.⁸¹ Marcia E's claim was based on the emergency department's failure to seek judicial endorsement for emergency admission within the first twenty-four hours of holding her in the emergency department in violation of section 3863.⁸² At the time, the statute did not authorize holding someone against their will for longer than twenty-four hours.⁸³ In its opinion, the Law Court stated that "[u]nder no circumstances may a hospital hold a person against his or her will for longer than twenty-four hours unless the hospital has obtained a judge's endorsement."⁸⁴ Ultimately, however, the court held that the hospital's failure to abide by the judicial endorsement requirement to hold Marcia on an emergency basis did not defeat the validity of her detention at the commitment phase because the procedures for each were "separate and distinct."⁸⁵ The opinion implied that the remedy for a person who is subjected to detention in the emergency department in violation of the statutory time limit and procedure is to seek a writ of habeas corpus.⁸⁶

Just over a year after *In re Marcia E.*, Representative Richard Malaby introduced L.D. 1738, An Act to Improve Maine's Involuntary Commitment Processes, to the 126th Maine Legislature on January 21, 2014.⁸⁷ The bill proposed multiple reforms to Maine's involuntary commitment process, including amending section 3863 to allow hospitals to detain a psychiatric patient for up to four days based solely on a medical practitioner's certificate with an additional three day period authorized judicial endorsement.⁸⁸ The bill's sponsor, in his testimony to the Judiciary Committee, indicated that he was motivated to introduce the bill in part because of a Superior Court justice's call for the legislature "to provide a more effective remedy to mentally ill patients who are held in violation of state law, thus restoring a just balance between the interests of individual liberty and public safety."⁸⁹ The bill was met with opposition from mental health patient advocates⁹⁰ and was eventually passed as a resolution calling for the Chief Justice of the Maine Supreme Judicial Court to convene a working group of various stakeholders and report reform recommendations to the Judiciary Committee by the end of 2014.⁹¹

81. *See id.* ¶¶ 3-5.

82. *Id.* ¶¶ 1-5. Exactly why the hospital did not seek judicial endorsement within twenty-four hours of Marcia's detention is unclear from the opinion, but it appears that the hospital did not seek judicial endorsement until it could accommodate her in inpatient care. *See id.* ¶ 2.

83. 34-B M.R.S. § 3863(3)(B) (2021).

84. *In re Marcia E.*, 2020 ME 139, ¶ 6, 58 A.3d 1115.

85. *Id.* ¶ 9.

86. *See id.* ¶ 8.

87. L.D. 1738 (126th Legis. 2014).

88. *Id.* § 5.

89. *An Act to Improve Maine's Involuntary Commitment Processes: Hearing on L.D. 1738 Before the J. Standing Comm. on Judiciary*, 126th Legis. 4 (2014) (testimony of Representative Richard Malaby, sponsor of L.D. 1738).

90. *See, e.g., An Act to Improve Maine's Involuntary Commitment Processes: Hearing on L.D. 1738 Before the J. Standing Comm. on Judiciary*, 126th Legis. (2014) (testimony of Oamshri Amarsingham, Public Policy Council for the American Civil Liberties Union of Maine); *An Act to Improve Maine's Involuntary Commitment Processes: Hearing on L.D. 1738 Before the J. Standing Comm. on Judiciary*, 126th Legis. 1 (2014) (testimony of Mark C. Joyce, Managing Attorney at Disability Rights Center (now known as Disability Rights Maine)).

91. Resolves 2013, ch. 106.

The working group convened in August 2014 and, after “discuss[ing] at length the appropriate procedural safeguards to be applied when a patient is held in a community hospital’s emergency department for more than 24 hours,” it recommended lengthening the amount of time a psychiatric patient can be held against their will.⁹² The working group suggested retaining the initial twenty-four-hour period but authorizing an additional forty-eight-hour period if inpatient care could not be located in the first twenty-four hours, provided that the hospital made additional certifications in writing.⁹³ The group also recommended authorizing a second forty-eight-hour period if, after the first seventy-two hours, the hospital still could not find an appropriate placement but felt strongly that DHHS should step in at that stage to help secure an appropriate placement.⁹⁴ The working group appeared to contemplate the second forty-eight-hour period as an extraordinary measure only to be relied on in the rare circumstance that an inpatient bed could not be located in the first seventy-two hours. Their report indicated that hospitals “should be able to secure the necessary community resources or inpatient placements for most patients within the extended timeframe proposed.”⁹⁵ The report then went on to cite data from DHHS’s Office of Substance Abuse and Mental Health Services showing that only “approximately 3% of patients who were involuntarily committed to a psychiatric hospital between July 2013 and October 2014 had been held in an emergency department for greater than 72 hours before an inpatient placement was secured” to justify recommending the final forty-eight-hour holding period.⁹⁶

The working group’s recommendations were embodied in L.D. 1145, An Act to Improve Maine’s Involuntary Commitment Process, which was introduced to the 127th Maine Legislature by Representative Richard Malaby on March 31, 2015.⁹⁷ In his testimony to the Judiciary Committee, Representative Malaby stated that the purpose of the bill was to address the problem in the then-existing statute of what should happen to a boarded psychiatric patient when they reach the end of the twenty-four hour holding period.⁹⁸ He further indicated that the extended holding periods were intended as an interim solution to the longer-term problem of inpatient psychiatric bed availability.⁹⁹ This version of Representative Malaby’s bill was passed into law,¹⁰⁰ and the measures were incorporated into the version of the statute at issue in *A.S. v. LincolnHealth*.¹⁰¹

92. Judicial Branch Mental Health Working Group, Recommendations for Improving the Involuntary Commitment Process 4-5 (Dec. 15, 2014).

93. *Id.* at 4.

94. *Id.* at 5.

95. *Id.*

96. *Id.*

97. L.D. 1145 (127th Legis. 2015).

98. *An Act to Improve Maine’s Involuntary Commitment Processes: Hearing on L.D. 1145 Before the J. Standing Comm. on Judiciary*, 127th Legis. 1 (2015) (testimony of Representative Richard Malaby, sponsor of L.D. 1145).

99. *Id.* at 2.

100. P.L. 2015, ch. 309 (emergency, effective July 2, 2015).

101. See 34-B M.R.S. § 3863(3)(B)-(E) (2021). Newly effective legislation provided some updates to this section of the statute, but these updates are irrelevant for the purposes of this Note. See *id.* § 3863(7); L.D. 868 (130th Legis. 2021) (striking references in the statute to “physician or licensed clinical psychologist” and replacing them with “medical practitioner”).

II. A.S. v. LINCOLNHEALTH

A. Facts and Procedural Background

On February 24, 2020, law enforcement officers brought A.S. to the emergency department of LincolnHealth's Miles Hospital in Damariscotta where the staff apparently concluded that A.S. met the criteria for emergency involuntary admission to inpatient psychiatric treatment.¹⁰² Despite having completed sixteen Blue Paper applications beginning on February 24, the hospital did not seek judicial endorsement of any of the Blue Papers, believing that the statute did not require endorsement until the admitting hospital had been identified.¹⁰³ According to the hospital, this is because the judicial officer could not endorse the application or send it to the admitting hospital if such hospital had not been identified.¹⁰⁴ LincolnHealth conceded that there was no case law to support this interpretation of the statute, "but told the court that this 'practice . . . has been occurring . . . for several years . . . without any licensing violations being issued by [the] Department of Health and Human Services or any other entity objecting to this practice.'"¹⁰⁵

On March 13, 2020, the eighteenth day of his detention in the emergency department, A.S. filed a petition for a writ of habeas corpus in the Lincoln County Superior Court seeking release from the hospital, and the hearing was scheduled for March 20, 2020.¹⁰⁶ Before the start of the hearing, the parties submitted a set of stipulated facts—including the fact that LincolnHealth never submitted any of the sixteen Blue Paper applications to the court—and before the start of evidence, A.S. moved for judgment on the stipulated record, arguing that the appropriate remedy for his unlawful detention was release.¹⁰⁷ The Superior Court denied his request, and LincolnHealth proceeded to present evidence of the efforts it had undertaken to find A.S. an appropriate inpatient placement during his detention in the emergency room.¹⁰⁸ At the close of LincolnHealth's case, A.S. moved for judgment as a matter of law on the basis that LincolnHealth had not complied with section 3863(3) of title 34-B of the Maine Revised Statutes by failing to seek judicial endorsement of its actions.¹⁰⁹ Although the Superior Court was sympathetic that A.S. had been detained for such a long period without any court proceedings, it denied A.S.'s motion.¹¹⁰ After A.S. testified and all evidence was presented, the trial court made several findings and conclusions of law on the record. First, "the court concluded that the section 3863 process 'can be reset every 48 hours, based upon a new Blue Paper being completed.'"¹¹¹ The Superior Court then went on to state that "'the proper standard' for adjudicating a habeas petition pursuant to section 3804 'is whether as

102. A.S. v. LincolnHealth, 2021 ME 6, ¶¶ 1-2, 246 A.3d 157.

103. *Id.* ¶¶ 2, 17.

104. *Id.*

105. *Id.* ¶ 5.

106. *Id.* ¶ 2.

107. *Id.* ¶¶ 2-3.

108. *Id.* ¶¶ 3-4.

109. *Id.* ¶ 5.

110. *Id.* ¶ 6.

111. *Id.* ¶ 7.

of now, an application for emergency involuntary admission to a psychiatric hospital could be granted, and basically whether the Blue Paper criteria could be met.”¹¹² The Superior Court then found that the Blue Paper standard had been met by the evidence, and although the Superior Court did not specify which standard of review it applied in coming to this conclusion, it was clear to the Law Court from the record that the Superior Court had rejected the argument that a heightened standard should apply.¹¹³ The Superior Court even stated on the record that, had it applied the clear and convincing evidentiary standard, it would have had a harder time denying A.S.’s habeas petition.¹¹⁴ A.S. timely appealed the Superior Court’s decision, and was ultimately discharged from LincolnHealth’s emergency department on March 25, 2020, while his appeal was still pending.¹¹⁵ A.S. spent a total of thirty days in the emergency room.¹¹⁶

B. The Issues

The Law Court considered a total of five issues in its review of A.S.’s detention and habeas petition on appeal: (i) mootness, (ii) standard of review on appeal, (iii) application of section 3863, (iv) availability of habeas relief, and (v) due process and the standard of review for involuntary hospitalization.¹¹⁷ For purposes of this Note, the analysis of the application of section 3863 is of primary importance, so the other four issues and holdings will be considered briefly before proceeding to the statutory application analysis.

Because A.S. was released from the hospital while his appeal was pending, the court first considered whether to proceed to the merits of his appeal or to dismiss the appeal as moot due to the absence of an effective remedy.¹¹⁸ While the court recognized that the appeal was moot because A.S. was discharged and there was no real or effective relief the court could provide, it proceeded to the merits because the case presented questions of great public concern.¹¹⁹ Further, the injury was capable of repetition yet evading review, “because the process used by LincolnHealth is apparently used frequently by Maine’s nonpsychiatric hospitals when those hospitals are forced to ‘board’ psychiatric patients.”¹²⁰ The court acknowledged that Maine’s nonpsychiatric hospitals and the courts dealing with those hospitals are in need of guidance in this area.¹²¹

The court then determined which standard of review it should apply to trial court adjudications of “civil” (i.e., noncriminal) habeas petitions on appeal.¹²² The court announced that, after considering the standard of review of habeas petitions in the criminal context, and conducting a comparative analysis of the standard of review in

112. *Id.*

113. *Id.*

114. *See id.*

115. *Id.* ¶¶ 7-8.

116. *Id.*

117. *See id.*

118. *Id.* ¶ 8.

119. *Id.* ¶¶ 8-9.

120. *Id.*

121. *Id.*

122. *Id.* ¶ 11.

other jurisdictions, it would apply the abuse of discretion standard to appeals of civil habeas petitions going forward.¹²³ Thus, the court reviewed the Superior Court's "legal conclusions de novo, its factual findings for clear error, and its ultimate determination for abuse of discretion."¹²⁴

The court also considered the showings required for habeas relief and the remedies available in the mental health context.¹²⁵ Generally, a court considering a petition for a writ of habeas corpus looks simply to the causes of the imprisonment or restraint and hears evidence produced on either side, and the court will order the patient to be discharged if it finds there is no legal cause for such detention.¹²⁶ However, in mental health cases, the court's considerations must go beyond the strict legality of the restraint and consider the welfare of both the patient and the public to determine whether a writ of habeas corpus is appropriate.¹²⁷ The court's holding clarified that trial courts should first determine the legality of a hospitalization and then consider its remedial options, and tailor any relief to balance the individual's liberty interests with concerns for the safety of the individual and the community.¹²⁸ The court then offered an example of such a remedy, suggesting that courts could grant the writ of habeas corpus but stay the petitioner's release for twenty-four hours to give the hospital time to seek judicial endorsement of a Blue Paper application.¹²⁹ Because the trial court first determined that A.S. posed a risk of serious harm and denied the habeas petition based on that determination, it did not properly apply the habeas jurisprudence to A.S.'s situation.¹³⁰

A.S. argued that the trial court violated his right to due process when it applied a preponderance of the evidence standard, rather than a clear and convincing evidence standard, to determine that he posed a likelihood of serious harm to himself or others and justify his continued detention in the emergency department.¹³¹ In response, the hospital argued that the clear and convincing evidence standard was not required because A.S.'s detention was based on an emergency admission application which mandates only that the application be "regular and in accordance with the law" for a judge or justice to endorse it.¹³² Under a de novo standard of review, the court agreed that A.S.'s due process rights had been violated by the application of the less demanding evidentiary standard.¹³³ Because the length of time he had been detained at the time of the habeas hearing—twenty-five days—was so serious a deprivation of liberty, the fact that it was based on an application for emergency admission rather than one for involuntary commitment was not controlling.¹³⁴ The court acknowledged that "[a]lthough a section 3863(3) judicial

123. *Id.* ¶ 13-14.

124. *Id.*

125. *Id.* ¶¶ 26-30.

126. *Id.* ¶ 27.

127. *Id.*

128. *See id.* ¶¶ 29-30.

129. *Id.* ¶ 30.

130. *See id.* ¶ 29.

131. *Id.* ¶ 31.

132. *Id.* ¶ 34.

133. *Id.* ¶ 36.

134. *Id.* ¶ 35.

endorsement may authorize a hospital to detain an individual for up to 120 hours, A.S.'s detention far exceeded that limit, and even exceeded the duration of any commitment permissible without a hearing."¹³⁵ Thus, moving forward, courts presented with a similar factual situation should apply the clear and convincing evidence standard to determine whether detention should continue.¹³⁶

At the "crux of this appeal" was the proper application of the statute that authorizes emergency involuntary admissions, section 3863 of title 34-B of the Maine Revised Statutes.¹³⁷ The court reviews statutory interpretation *de novo*, looking "first to the plain language of the statute to determine its meaning if [the court] can do so while avoiding absurd, illogical, or inconsistent results."¹³⁸ As part of the plain language review, the court looks to the "entire statutory scheme in order to achieve a harmonious result."¹³⁹ The court examines legislative history to determine legislative intent only if the meaning of the statute's plain language, considered with the entire statutory scheme, is unclear.¹⁴⁰

The court began "by noting that section 3863 is an imprecise 'fit' for what is actually happening in Maine's emergency departments as they struggle to deal with patients who need psychiatric beds at a time when the State has failed to create or fund enough of those beds."¹⁴¹ A.S. argued that the hospital violated the statute by failing to submit any Blue Paper applications for judicial endorsement and by detaining him for longer than the statutorily authorized 120 hours.¹⁴² The hospital's counterargument was that it had fulfilled its statutory duties by repeatedly filling out the Blue Paper application and periodically having a medical practitioner complete certifying examinations of A.S.¹⁴³ The hospital contended that, because it was unable to identify an admitting inpatient hospital bed for A.S., it could not submit the application for judicial endorsement because the judicial officer could not endorse the application as "regular and in accordance with the law" if no inpatient placement had been identified.¹⁴⁴ Similarly, the officer could not promptly send the application and examination certificate to the admitting hospital if no hospital had been secured.¹⁴⁵

The court's analysis started with its interpretation of the previous version of section 3683(3) where, in deciding *In re Marcia E.*, it announced that "[u]nder no circumstances may a hospital hold a person against his or her will for longer than twenty-four hours unless the hospital has obtained a judge's endorsement."¹⁴⁶ The court then noted the legislative history that changed the statute to allow for the two

135. *Id.*

136. *See id.* ¶ 36.

137. *Id.* ¶ 15.

138. *Id.*

139. *Id.*

140. *Id.*

141. *Id.* ¶ 16.

142. *Id.* ¶ 17.

143. *Id.* ¶¶ 17, 34.

144. *Id.* ¶ 17.

145. *Id.*

146. *Id.* ¶ 19 (quoting *In re Marcia E.*, 2012 ME 139, ¶ 6, n.3, 58 A.3d 1115).

additional forty-eight hour hold periods.¹⁴⁷ “Three years after [*Marcia E.*], in response to concerns that, due to Maine’s severe shortage of psychiatric beds, section 3863(3)(B)’s emergency twenty-four-hour hold provided insufficient time for a nonpsychiatric hospital to locate a psychiatric bed for a patient in crisis, paragraphs (D) and (E) of section 3863(3) were enacted.”¹⁴⁸ To support this assertion of legislative intent, the court cited, *inter alia*, the testimony of the Maine Hospital Association in support of the bill that initiated the change to the statute.¹⁴⁹ The court went on to conclude that because the 2015 amendments did not change the statutory language of section 3863(3)(B)(2),¹⁵⁰ hospitals seeking to detain people pending admission to inpatient psychiatric treatment must still obtain judicial endorsement within the first twenty-four hours of such detention.¹⁵¹ The court rejected LincolnHealth’s interpretation of the statute that there are no due process protections for patients at the Blue Paper stage because the due process protections of section 3684 do not “kick into full effect” until a person is involuntarily admitted into a psychiatric hospital.¹⁵² To support rejecting LincolnHealth’s argument, the court noted that such an interpretation was not supported by the language of the statute nor the case law.¹⁵³ The court went one step further by referencing legislative intent stating that it could not “accept the premise that . . . the Legislature intended to allow individuals to be held in emergency departments for days or weeks without *any* legal process or safeguards,” but then went on to stress that the language of the statute is unambiguous.¹⁵⁴ Thus, even though the application is technically incomplete without identifying an inpatient psychiatric bed for the person to be detained, hospitals still must seek judicial endorsement within the first twenty-four hours of detention to be in compliance with the law.¹⁵⁵

The court then interpreted the statute to determine what hospitals can legally do if, as in the case of A.S., the statutorily authorized 120 hours run out and the person still poses a likelihood of serious harm.¹⁵⁶ Using plain language interpretation, the court announced that “[i]f the patient cannot be safely released after the entire 120-hour authorized hold period has lapsed and if there is still no psychiatric bed available, the hospital may ‘restart’ the process.”¹⁵⁷ To properly restart the process,

147. *Id.* ¶ 20.

148. *Id.*

149. *Id.*; *An Act to Improve Maine’s Involuntary Commitment Processes: Hearing on L.D. 1145 Before the J. Standing Comm. on Judiciary*, 127th Legis. (2015) (testimony of Jeffrey Austin, on behalf of the Maine Hospital Association).

150. “A person may not be held against the person’s will in a hospital under this section, except that a person for whom an examiner has executed the certificate under subsection (2) may be detained in a hospital for a reasonable period of time, not to exceed 24 hours, pending endorsement by a judge or justice, if: . . . (2) For a person sought to be involuntarily admitted under this section, the person or persons seeking the involuntary admission undertake to secure the endorsement immediately upon execution of the certificate by the examiner.” 34-B M.R.S. § 3863(3)(B)(2) (2021).

151. A.S., 2021 ME 6, ¶ 21, 246 A.3d 157.

152. *Id.* ¶ 24.

153. *Id.*

154. *Id.*

155. *See id.* ¶¶ 21-24.

156. *See id.* ¶ 25.

157. *Id.*

the hospital must complete “a new application and certifying examination, including adequate and updated information relevant to the individual at that moment in time, [and] submit[] [it] for judicial endorsement within twenty-four hours after the 120-hour period ends.”¹⁵⁸ The court supported this interpretation by noting that there is nothing in the statute that prohibits the restarting practice.¹⁵⁹ It then elaborated on that point in a footnote, first acknowledging that the statute is silent on what should happen to the person after the first 120 hours elapse, then stating “but if the Legislature intended that the hospital must discharge that patient, it would have expressed that intention in that portion of the statute, just as it did in section 3863(5-A).”¹⁶⁰ That section requires psychiatric hospitals to file a White Paper application with the district court within the first three days that a person is admitted to the hospital pursuant to a Blue Paper application or else discharge the patient.¹⁶¹

C. Holdings and Ultimate Disposition of the Case

Finally, the court wrote a summary of its holdings to clarify the processes hospitals must follow to comply with section 3863 and the procedure trial courts must follow when presented with a habeas petition arising from detentions in an emergency room.¹⁶² This case clarified that, even if an emergency room seeking to have a patient admitted to inpatient care has not yet located an inpatient bed, the hospitals must seek judicial endorsement of the application within the first twenty-four hours of holding that patient.¹⁶³ Once the application has been endorsed by a judicial officer, the hospital may continue to hold that patient for two additional forty-eight hour periods provided that the hospital follows the additional steps called for by the relevant statute.¹⁶⁴ To properly decide the appropriateness of a habeas petition and provide any relief, trial courts must first evaluate the legality of the restraint and then order a tailored, appropriate remedy.¹⁶⁵ When the detention is lengthy, as in the case of A.S., the hospital has the burden of persuading the court by clear and convincing evidence that continued hospitalization is necessary.¹⁶⁶ Because LincolnHealth failed to submit a single Blue Paper application to the court, A.S.’s detention was unlawful, and the trial court should have declared the detention unlawful and then determined an appropriate remedy.¹⁶⁷ Thus, the Law Court vacated the judgment of the trial court denying A.S.’s petition for a writ of habeas corpus.¹⁶⁸

158. *Id.*

159. *Id.*

160. *Id.* ¶ 25 n.6.

161. *Id.*

162. *See id.* ¶¶ 37-38.

163. *Id.* ¶ 37.

164. *Id.*; *see* 34-B M.R.S. § 3863(3)(D)-(E) (2021).

165. *A.S.*, 2021 ME 6, ¶ 38, 246 A.3d 157.

166. *Id.*

167. *Id.*

168. *Id.*

D. Analysis and Critique: Section 3863

The court's opinion in *A.S. v. LincolnHealth* essentially endorses the practice of psychiatric boarding with only the barest procedural protections for patients held in the emergency room for longer than 120 hours against their will,¹⁶⁹ but the court was working with few viable options in the absence of legislative guidance. It is clear that the protection provided to boarded patients is minimal under the court's opinion. A judicial officer reviewing an application for emergency involuntary admission must endorse the application if it is "regular and in accordance with the law," leaving little to no room for discretion, and the basis for endorsement comes from only the hospital's assertion of facts.¹⁷⁰ While the exigency of a person who poses a likelihood of serious harm to themselves or others presenting at the emergency room justifies this procedure in the early days of detention, it is unclear why these bare procedural safeguards should be sufficient beyond the statutorily authorized 120 hours. Further, it is a strained reading of the statute and statutory scheme to say that restarting the Blue Paper application process every 120 hours indefinitely is not prohibited by the law.

A plain language reading of the statute, of course, cannot end by observing that the statute is silent on what hospitals should do when they have held a patient against their will for the full 120 hours who still poses a likelihood of serious harm, but has not been accepted for an inpatient psychiatric bed. However, the result the Law Court reached is arguably inconsistent when considered in context with the statutory scheme. As the court itself acknowledges, by the time of A.S.'s hearing on his habeas petition, "A.S.'s detention far exceeded that [120 hour] limit, *and even exceeded the duration of any commitment permissible without a hearing.*"¹⁷¹ Section 3863(5-A) requires the inpatient hospital seeking commitment longer than three days to submit the commitment application to the district court within the first three days or release the patient.¹⁷² The district court must hold a hearing within fourteen days of receipt of the application.¹⁷³ Altogether, this shows that the Legislature contemplated a period of no longer than twenty-two days that one may be hospitalized against their will without being able to have their case and evidence considered by a judge.¹⁷⁴

Even under this calculation, the patient who has been held against their will and then admitted to psychiatric inpatient care is afforded more due process protections upon their arrival and subsequent commitment (White Paper) application than a patient who is being boarded against their will in an emergency room. For example,

169. *See id.* ¶ 25.

170. *See* 34-B M.R.S. § 3863(3)(A) (2021).

171. *A.S.*, 2021 ME 6, ¶ 35, 246 A.3d 157 (emphasis added).

172. 34-B M.R.S. § 3863(5-A)(C) (2021).

173. *Id.* § 3864(5)(A).

174. The twenty-two day calculation assumes that a person waits the entire 120 hours in the emergency room (five days), the admitting hospital waits the entire three days to submit the application, and the court does not schedule a hearing until the fourteenth day after receiving the application. The actual period one could lawfully wait without having a hearing could exceed twenty-two days because the statute does allow for additional time to file the application if the third day falls on a weekend or holiday. *Id.* § 3863(5-A)(C). And the district court may continue the hearing for an additional twenty-one days but only for good cause shown. *Id.* § 3864(5)(A)(1).

upon admission to inpatient care, the psychiatric hospital must consult with the patient and then provide notice of their hospitalization to an appropriate emergency contact, though no such notification requirement exists at the Blue Paper stage.¹⁷⁵ Every patient admitted under section 3863 must be evaluated by a staff medical practitioner “as soon as practicable” after admission and within twenty-four hours, and if the second opinion of that practitioner does not agree with the emergency room that the patient poses a likelihood of serious harm, the patient must be discharged.¹⁷⁶

Moreover, before the White Paper application can be filed, the hospital must inform the patient and their guardian or next of kin of the patient’s right to hire counsel or have counsel appointed, their right to select themselves or have their attorney select an independent examiner, and how they can contact the district court.¹⁷⁷ The hospital must submit proof of these notifications to the district court with the application, and the court must, within two days of filing, send notification of the filing to the patient.¹⁷⁸ The court will order another examination before the hearing and if the person does not obtain counsel on their own, the court must appoint counsel.¹⁷⁹ In the intervening time between the White Paper application and the hearing, the court may order discharge to a guardian or next of kin upon request, upon a report of the hospital applicant that the person may be discharged safely, or upon writ of habeas corpus.¹⁸⁰ Although the person has not yet had an opportunity to present their evidence and be heard, they are afforded significantly more due process protections as soon as they arrive at inpatient care than if they are boarded in the emergency room beyond 120 hours.

In the context of the entire statutory scheme, it is inconsistent to interpret the statute’s plain meaning to allow for indefinite “restarting” of the emergency involuntary application process every 120 hours until the patient is admitted to inpatient care or no longer imposes a likelihood of serious harm. The entire involuntary hospitalization statutory scheme provides for “stepped up” due process protections and requirements for hospitals that increase as the length of the involuntary hold increases. It is inconsistent and illogical for these stepped-up procedures to step back down every 120 hours when the Blue Paper process is “restarted.” This is especially so given the significant disparity of due process protections required between the Blue Paper phase and the White Paper phase.

Given the absurdity of the result of the plain language reading of the statute, the Law Court should have proceeded to fully consider legislative intent to properly interpret the statute and provide guidance to hospitals moving forward.¹⁸¹ The Judicial Branch Mental Health Working Group’s report to the Judiciary Committee would have been particularly instructive of legislative intent. This is because the

175. Compare 34-B M.R.S. § 3863(6)(A)-(E) (requiring notice to patient’s next of kin upon admission to inpatient care), with 34-B M.R.S. § 3863(1)-(5-A) (establishing that notice to next of kin is not required at the Blue Paper stage).

176. 34-B M.R.S. § 3863(7)-(7-A) (2021).

177. *Id.* § 3864(1)(D)(1)-(3).

178. *Id.* § 3684(1)(E), (3)(A)(1).

179. *Id.* § 3864(4), (5)(D).

180. *Id.* § 3864(2)(A)-(C).

181. As discussed above, the court did at least acknowledge the legislative history that led to the statutory changes relevant to its decision. *A.S. v. LincolnHealth*, 2021 ME 6, ¶ 20, 246 A.3d 157.

working group was deputized to undertake the policy analysis by legislative resolve, its members were selected and appointed by the Chief Justice, and its membership represented various stakeholders from state government, hospitals, patients' rights advocates, and affected family members.¹⁸² While the working group was also silent on what should happen if its recommended 120 hour period ran out while the patient was still in the emergency room, its recommendations make clear that it did not intend for emergency rooms to be able to hold a patient involuntarily longer than 120 hours.¹⁸³ In the working group's explanation of its recommendation for the second forty-eight hour hold period, it wrote "while hospitals should be able to secure the necessary community resources or inpatient placements for most patients within the extended timeframe proposed above, circumstances might arise where necessary resources do not become available as quickly as they are needed."¹⁸⁴ The working group recommended authorizing the second forty-eight hour period based on DHHS data that only 3% of patients who were involuntarily admitted to psychiatric hospitals waited in emergency rooms for longer than seventy-two hours before admission.¹⁸⁵ Additionally, with each recommended forty-eight hour holding period, the working group recommended stepped up procedural safeguarding requirements to ensure that patients were being evaluated by someone with "heightened psychiatric expertise," and that DHHS would lend its "expertise and assistance to the hospital."¹⁸⁶ The working group's recommendations advocate for heightened due process requirements as the length of involuntary detention increases. The indefinite "restarting" of the Blue Paper application process is inconsistent with the working group's concerns. Further, not one piece of testimony offered on the bill that initiated the statutory changes advocated for authorizing a total holding period of more than 120 hours.¹⁸⁷ If the Law Court had fully considered legislative intent as part of its statutory interpretation, its holding that hospitals could simply "restart" the Blue Paper application process could not stand.

Although the court's reading of the statute is strained to get to the statutory interpretation that it announced, the interpretation is understandable given the context and the court's limited authority to craft a solution wholesale without legislative guidance. It would be hard to defend an interpretation that required the emergency room to release a patient after 120 hours regardless of whether the patient still posed a likelihood of serious harm, and would likely put emergency rooms at

182. See Judicial Branch Mental Health Working Group, Recommendations for Improving the Involuntary Commitment Process I (Dec. 15, 2014).

183. See *id.* at 4-5.

184. *Id.* at 5.

185. *Id.*

186. See *id.* at 4-5.

187. See, e.g., *An Act to Improve Maine's Involuntary Commitment Processes: Hearing on L.D. 1145 Before the J. Standing Comm. on Judiciary*, 127th Legis. (2015) (testimony of Representative Richard Malaby, sponsor of L.D. 1145); *An Act to Improve Maine's Involuntary Commitment Processes: Hearing on L.D. 1145 Before the J. Standing Comm. on Judiciary*, 127th Legis. (2015) (testimony of Jeffrey Austin, Maine Hospital Association); *An Act to Improve Maine's Involuntary Commitment Processes: Hearing on L.D. 1145 Before the J. Standing Comm. on Judiciary*, 127th Legis. (2015) (testimony of Mark Joyce, Managing Attorney of Disability Rights Maine); *An Act to Improve Maine's Involuntary Commitment Processes: Hearing on L.D. 1145 Before the J. Standing Comm. on Judiciary*, 127th Legis. (2015) (testimony of Dr. Michelle Gardner, Medical Director, Dorothea Dix Psychiatric Center).

risk of violating their duty to stabilize or transfer patients under the Emergency Medical Treatment and Labor Act.¹⁸⁸ Further, because of the silence of the statute on the appropriate course of action at the end of the 120 hours, the court would essentially be legislating new procedures without the benefit of the deliberative legislative process. The court was also put in a tough position, as it noted, because “the State has failed to create or fund enough [inpatient psychiatric] beds.”¹⁸⁹ Although the creation of more psychiatric beds certainly could alleviate emergency room boarding, the problem runs much deeper than just inpatient capacity. DHHS has licensed 500 inpatient psychiatric beds, but many of the bed licenses remain unused,¹⁹⁰ so the underlying issue is not the failure to create more beds. Systemic solutions should focus on community mental health resources to prevent the extreme and stigmatizing option of involuntary commitment, but any type of systemic solution that would prevent hospitalization is beyond the court’s reach.

III. AFTER *A.S.*: DEVELOPMENTS AND PROPOSALS FOR THE FUTURE

As discussed above, the mental health care system is in crisis due to the competing forces of deinstitutionalization and the lack of effective and readily available community mental health services. The large-scale, long-term solutions that would keep people from reaching a crisis point requiring hospitalization are beyond the scope of this Note, but helpful developments have arisen after *A.S.* and this Note proposes several short-term and easily achievable solutions that would reduce the instances and lengths of psychiatric boarding in Maine.

A. Recent Developments

Just over a month after the Law Court issued its opinion in *A.S. v. LincolnHealth*, DHHS published a new Blue Paper form and a supplemental form to reflect the holdings of the case and the realities of psychiatric boarding.¹⁹¹ The new Blue Paper form contains separate fields for judicial endorsement when a psychiatric hospital is identified in the application and for when a psychiatric hospital has not yet been identified.¹⁹² For hospitals facing the latter situation, DHHS published a supplemental form to be submitted to the court as a follow up once a psychiatric hospital has been identified.¹⁹³ These new forms are a better fit for the situation

188. See Emergency Medical Treatment & Labor Act, 42 U.S.C. § 1395dd.

189. *A.S. v. LincolnHealth*, 2021 ME 6, ¶ 16, 246 A.3d 157.

190. Joe Lawlor, *Sanford Medical Center Opening Psychiatric Center to Help Ease Shortage*, PORTLAND PRESS HERALD (Oct. 20, 2020), <https://www.pressherald.com/2020/10/20/sanford-medical-center-opening-psychiatric-center-will-help-ease-shortage/> [<https://perma.cc/5RQ6-8CEF>].

191. Me. Dep’t of Health and Hum. Servs., Memo re: Revisions to Forms for the Emergency Involuntary Hospitalization Process (March 2, 2021), https://www.maine.gov/dhhs/sites/maine.gov/dhhs/files/inline-files/notificafication-re-new-Blue-Paper-forms-3-2-2021-signed_0.pdf [<https://perma.cc/7PA-M-JWDT>].

192. Me. Dep’t of Health and Hum. Servs., State of Maine “Blue Paper” Application for Emergency Involuntary Admission to a Psychiatric Hospital (March 1, 2021), https://www.maine.gov/dhhs/sites/maine.gov/dhhs/files/inline-files/Blue-Paper-MH-100.A%28Rev.-March-2021%29_0.pdf [<https://perma.cc/PSJ3-X7MY>].

193. Me. Dep’t of Health and Hum. Servs., State of Maine “Blue Paper” Notification to Judicial Officer of Identification of Psychiatric Hospital (March 1, 2021), <https://www.maine.gov/dhhs/sites/maine.gov>.

emergency rooms are facing and resolve the confusion that LincolnHealth and other hospitals were experiencing before *A.S.* by making clear that even if a psychiatric hospital has not been identified, a hospital must still seek judicial endorsement within the first twenty-four hours of detention. In addition to the new, more appropriate forms, if a hospital is “restarting” the Blue Paper application process because the statutorily authorized 120 hours has expired, the hospital “must attach and provide all immediately preceding Blue Paper applications for the proposed patient to the judicial officer.”¹⁹⁴ By including the preceding Blue Paper applications in the subsequent “restarting” applications, the endorsing judicial officer is put on notice that the patient is being subjected to an extended detention and may afford the subsequent “restarted” Blue Paper applications heightened scrutiny.

B. Proposals for the Future

Although large-scale systemic changes to the mental healthcare system are necessary to prevent the extreme liberty deprivation of inpatient hospitalization, these changes will need to come from the state and federal legislatures with the advocacy of stakeholders and are beyond the scope of this Note. There are, however, easily attainable short-term measures that can increase the due process rights of people with mental illness in Maine and reduce the instances of extended detentions in emergency rooms. These reforms include greater transparency and appointment of counsel.

1. Transparency

The involuntary admission and commitment processes are shrouded in secrecy, in part to protect patients’ identities, but there are areas for improvement that do not implicate patient privacy. As discussed above, data on psychiatric boarding is not published by DHHS but appears to be within its purview to collect and publish if it chooses to.¹⁹⁵ Such data, if collected and made public would help policy makers should they consider making further changes to the statute, to increase due process protections for people subjected to extended emergency room detentions. Armed with this data, advocates would be able to demonstrate the scope of the problem to persuade policy makers to take up the charge. Also, if the data contained demographic information, it would expose any disparities in psychiatric boarding instances and lengths among demographic groups.

Beyond data transparency, greater transparency of admissions standards to inpatient psychiatric care and inpatient bed availability would help emergency rooms understand how to effectively advocate for getting patients admitted, thereby decreasing boarding times in emergency rooms. As it stands, few of the inpatient

dhhs/files/inline-files/Blue-Paper-Notification-MH-100.B%28March-2021%29.pdf [https://perma.cc/NP Y8-L3H2].

194. Me. Dep’t of Health and Hum. Servs., State of Maine “Blue Paper” Application for Emergency Involuntary Admission to a Psychiatric Hospital (March 1, 2021), https://www.maine.gov/dhhs/sites/maine.gov/dhhs/files/inline-files/Blue-Paper-MH-100.A%28Rev.-March-2021%29_0.pdf [https://perma.cc/X7FC-JCLV].

195. See Recommendations for Improving the Involuntary Commitment Process 5 (Dec. 15, 2014).

hospitals make their admissions criteria or open bed capacity publicly available.¹⁹⁶ DHHS does not appear to publish a unified database of current inpatient bed availability,¹⁹⁷ but such a database would be an efficient way for emergency room staff to monitor appropriate inpatient openings.¹⁹⁸ Further, inpatient psychiatric hospitals are not under the same obligation to treat and stabilize patients as emergency rooms,¹⁹⁹ leaving them relatively unconstrained in their discretion to decline patients in need of care. The discretionary nature of inpatient admission is likely a driving force behind the psychiatric boarding crisis and cuts against any solution that simply adds more beds to the state because the addition of more beds would be meaningless if the people who need them are not accepted for admission to psychiatric hospitals. DHHS should leverage its licensing power²⁰⁰ to create a more unified, transparent admissions system and limit the inpatient psychiatric hospitals' ability to decline patients. The legislature should also consider codifying admission standards for inpatient psychiatric care and limiting hospital discretion by statute.

2. Appointment of Counsel

Appointment of counsel for patients held in emergency rooms who wish to challenge their detention is arguably required by the Law Court's holding in *In re Penelope W.*²⁰¹ In that case, the court held that the involuntary commitment statute requires that the person who is the subject of a petition for involuntary commitment "be provided counsel at every stage of the proceeding."²⁰² Counsel is required because such proceedings "inevitably involve substantial questions regarding the mental status of the person who is the subject of the application."²⁰³ Thus, "[p]ermitt[ing] such persons to proceed without the benefit of an attorney runs the risk

196. See, e.g., *Adult Inpatient Psychiatric Unit (A-3)*, ST. MARY'S HEALTH SYS., [https://www.stmarysmaine.com/departments-services/mental-health-detox/adult-inpatient-psychiatric-unit-\(a-3\)](https://www.stmarysmaine.com/departments-services/mental-health-detox/adult-inpatient-psychiatric-unit-(a-3)) [<https://perma.cc/6Z3R-7WEF>] (last visited May 11, 2022); *Behavioral Health*, CENT. ME. MED. CTR., <https://www.cmhc.org/emmc/services/behavioral-health/> [<https://perma.cc/JY9L-3BLZ>] (last visited May 11, 2022). But see SPRING HARBOR HOSP., *Adult Inpatient Services: Admission Criteria*, <https://www.mainehealth.org/Spring-Harbor-Hospital/Services/Adult-Inpatient> [<https://perma.cc/2FTB-T8QQ>] (last visited May 11, 2022).

197. See *Data & Research*, STATE OF ME. DEP'T OF HEALTH & HUM. SERVS., <https://www.maine.gov/dhhs/obh/about/data-research> [<https://perma.cc/2DVV-FEUA>] (last visited May 11, 2022).

198. The Massachusetts Behavioral Health Partnership administers the Massachusetts Behavioral Health Access platform, a website accessible by the public and service providers with up to the minute information on mental health service openings, including open inpatient psychiatric beds. *Mental Health Services*, MASS. BEHAV. HEALTH P'SHIP, <https://www.mabhaccess.com/MH.aspx> [<https://perma.cc/C66B-RVLW>] (last visited May 11, 2022). DHHS or a private hospital system should consider building a similar platform for Maine to assist emergency room staff as they search for inpatient placements.

199. See Emergency Medical Treatment & Labor Act, 42 U.S.C. § 1395dd(b), (e)(5) (establishing that the requirement for hospitals to stabilize or transfer applies only to emergency medical services).

200. See *Licensing & Certification: Medical Facilities: Hospitals*, STATE OF ME. DEP'T OF HEALTH & HUM. SERVS., <https://www.maine.gov/dhhs/dlc/licensing-certification/medical-facilities/hospitals> [<https://perma.cc/NBC8-2JNE>] (last visited May 11, 2022).

201. *In re Penelope W.*, 2009 ME 81, ¶ 9, 977 A.2d 380.

202. *Id.* ¶ 7.

203. *Id.* ¶ 10.

of giving those who may be incompetent the task of proving their own competence.”²⁰⁴

The same policy justifications that support mandatory appointment of counsel at the involuntary commitment stage also weigh in favor of appointing counsel at the habeas petition stage. This is because a patient filing a habeas petition must advocate for their own competence after they have been alleged to be incompetent.²⁰⁵ Unfortunately, the judicial branch has declined to give guidance on whether counsel will be appointed for patients filing a habeas petition because doing so would amount to an advisory opinion.²⁰⁶ Because the judicial branch will not issue an advisory opinion on whether counsel is required when a patient wishes to file a petition for a writ of habeas corpus, the legislature should amend section 3804 of title 34-B of the Maine Revised Statutes to make clear that counsel is required when requested for this purpose.

Appointed counsel at the habeas petition stage is only useful to the extent that a patient knows of the availability of such a proceeding and remedy.²⁰⁷ When a patient is subjected to extended emergency room detention beyond the statutorily authorized 120 hours, they should at least be informed of their rights and given contact information for advocacy organizations and the courts. To this end, the Law Court’s opinion in *A.S.* supports the need for appointed counsel after the statutorily authorized 120 hours has expired because the person’s detention becomes indefinite at that point.²⁰⁸ Moreover, under the Supreme Court’s holding in *Addington v. Texas*, a patient who is subject to involuntary commitment proceedings for an indefinite period of detention is afforded heightened due process protections.²⁰⁹ Further, under the Law Court’s holding in *In re Penelope W.*, a patient who is subject to such proceedings must be represented by counsel at every stage of those proceedings.²¹⁰ Considered together, the holdings in these three cases compel the conclusion that patients subjected to extended emergency room detentions are being held indefinitely, and thus must be provided counsel. While boarded patients face an uphill battle for a writ of habeas corpus to be granted, the presence of appointed counsel and the filing of the habeas petition can put needed pressure on the system to get a patient admitted to inpatient care or released into the community when appropriate.

204. *Id.*

205. *See A.S. v. LincolnHealth*, 2021 ME 6, ¶ 27, 246 A.3d 157.

206. Letter from James T. Glessner, State Ct. Adm’r, Admin. Off. of the Cts. to Mark Joyce, Managing Att’y, Disability Rts. Me. & Emma Bond, Legal Dir., Am. Civ. Liberties Union of Me., (Mar. 17, 2021) (on file with author).

207. In *A.S.*, the only reason *A.S.*’s extended detention in the emergency room came to light was because he already had appointed counsel on an unrelated matter who learned of his detention and filed the petition for a writ of habeas corpus. Zoom Interview with James P. Bailinson, Corp. Couns., MaineHealth (Feb. 18, 2022).

208. *See A.S.*, 2021 ME 6, ¶ 25, 246 A.3d 157 (interpreting the statute to allow for indefinite “restarting” of the Blue Paper process).

209. *Addington v. Texas*, 441 U.S. 418, 427 (1979).

210. *In re Penelope W.*, 2009 ME 81, ¶ 7, 977 A.2d 380.

CONCLUSION

The due process rights of patients with mental illness who experience significant deprivations of their liberty due to involuntary hospitalization are considered important by the Supreme Court,²¹¹ but exactly how to protect those rights while balancing the state's interest in public safety in light of limited resources has proven difficult in practice. While the entire mental healthcare system is in need of reform, *A.S. v LincolnHealth* brought attention to the need for short-term reforms that will protect the due process rights of boarded emergency room patients in Maine. Efforts to reform the system should first look to transparency in data collection and admission criteria and the appointment of counsel. Long-term goals should include improving access to community-based mental health services and modifying section 3863 of title 34-B of the Maine Revised Statutes to include stronger due process protections for vulnerable patients.

211. See *Addington*, 441 U.S. at 427.